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House Committee on Foreign Affairs: Subcommittee on Africa, Global Health, Global Human Rights, and International Organizations

Combating the Ebola Threat

August 7, 2014

Chairman Smith, esteemed members of this council and fellow guests of this committee; I am privileged to testify before you today on the developments of the Ebola outbreak in West Africa and Samaritan's Purse response.

Samaritan's Purse is an international NGO with 38 years of experience dedicated to humanitarian relief. We have worked in over one hundred countries including Afghanistan, North Korea, South Sudan, Sudan, Syria, and Liberia. As an organization, we have responded to medical emergencies such as the cholera epidemic in Haiti and we have provided medical care to the people of Bosnia, Rwanda, and Sudan during the genocides in those countries. The Ebola outbreak has had a profound impact on our organization, and I would like to share with you about our experience in Liberia.

I want to take this opportunity to thank the United States government, the Department of State, and the Department of Defense for assisting Samaritan's Purse in the evacuation of our sick personnel from Liberia. We would specifically like to call to attention and thank Kathleen Austin-Ferguson of the Department of State, Dr. William Walters of the Department of State, and Phil Skotte of the State Department, Mr. Dent Thompson, and Congressman Wolf. We would also like to thank certain staff members of the CDC and the NIH for bringing to our

attention and obtaining the experimental medication used as a treatment option for our, two infected staff members.

As an organization, we have worked to contain the growing Ebola crisis in Liberia and were devastated to discover that two of our personnel had contracted the deadly virus while trying to assist others. The support that the United States government has shown to our organization is tremendous, and Samaritan's Purse thanks you for helping us bring the two of them home in the face of incredible challenges.

The Ebola crisis we are now facing is not a surprise to us at Samaritan's Purse, but it took two Americans getting the disease in order for the international community and the United States to take serious notice of the largest outbreak of the disease in history. Yesterday the President of Liberia declared a State of Emergency in the nation. This declaration is at least a month late.

Ebola is an incredibly infectious virus that begins with flu-like symptoms and can quickly develop into internal hemorrhaging. First discovered in 1976, the disease has predominately manifested in Uganda, Congo and South Sudan. In the 32 years since it was discovered (1976-2008) there were 2,232 known infections which killed 1503.[1] Until this current outbreak, the virus has never appeared in heavily populated areas but is now attacking the major cities of Sierra Leone, Liberia, Guinea and Nigeria. Lagos, Nigeria, alone has a population of 25 million people and the other cities have populations exceeding two million each. The infection and death rates of this recent West African outbreak will easily and quickly surpass the combined total of all previous outbreaks. The disease is uncontained and out of control in West Africa.

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[1] Bulletin of the World Health Organization, Ebola Haemorrhagic Fever in Zaire, 1976: Report of an International Commission, 56 (2): 271-293 (1978). World Health Organization, Ebola Virus Disease, West Africa Update http://www.who.int/csr/don/2014_07_31_ebola/en/, July 31, 2014.

A broader coordinated intervention of the international community is the only thing that will slow the size and speed of the spread of the disease. Currently, WHO reports 1,711 Ebola diagnoses and 932 deaths in West Africa. We believe the reported numbers only show 25-50% of the cases.

The Ministries of Health in Guinea, Liberia and Sierra Leone do not have the capacity to handle these crises in their countries. If a mechanism is not found to create an acceptable paradigm for the international community to become directly involved, then the world will be relegating the containment of this disease that threatens Africa and other countries to three of the poorest nations in the world.

Samaritan's Purse initially focused its efforts on a massive public awareness campaign in which over 430,000 have been reached, but there are over 3.6 million people in Liberia and the literacy rate is very low. We had hoped to not become involved in direct clinical care but as the disease resurged in June, we had no choice. We began operating case management centers in the two most directly affected areas of the country: Foya and Monrovia.

In the first months, we provided support to WHO, CDC, MOH, and MSF with our two aircraft as we flew personnel, supplies and specimens back and forth across the country. We consulted closely with these organizations in establishing our Case Management Centers (Ebola isolation wards) and greatly appreciate their help. I want to take this opportunity to recognize the bravery and dedication of MSF for being in the "trenches" with us.

In mid-June, I began speaking privately to US officials that the disease was spiraling out of control and more needed to be done immediately. In mid-July, I published an op-ed article in the NY Times calling for an increased and accelerated response to this horrific disease.

Samaritan's Purse and MSF continued to be the two primary care givers, MSF in Guinea and Sierra Leone and SP in Liberia. That the world would allow two relief agencies to shoulder this burden along with the overwhelmed Ministries of Health in these countries testifies to the lack of serious attention the epidemic was given.

It was not until Dr. Kent Brantly and Mrs. Nancy Writebol were identified as Ebola positive on July 26th that serious international attention was paid to the crisis. Both individuals served on the Samaritan's Purse Ebola response team and both became gravely ill. With the help of the Department of State and other American government agencies we were able to arrange their air evacuations to Emory University Hospital for continued treatment where they still remain.

Treatment of Ebola requires personnel with knowledge and tools, but those medical professionals require assurance that if they become sick, they have the option to be adequately treated. During the evacuation of the two members of our team, it came to my attention that there was only one plane in the world with the ability to safely transport a patient with a level four pathogenic disease. The United States needs the capacity to evacuate multiple citizens at a time.

Over the last two weeks, it has become clear to the world that Ebola is out of control as we read headlines daily of new or potential cases in multiple countries including the United States. Responding to the disease exceeded the total capacity of SP in Liberia even though we had direct assistance from WHO, MSF, MOH, CDC and 400 of our national staff. We have removed all expatriate personnel and returned them to their home countries. While our Liberian office remains open, all program activity has been suspended except for ongoing Ebola

awareness campaigns. We are no longer able to provide clinical patient care, and MSF has stepped into that gap. We are in the process of planning our return into Liberia to continue the fight.

The global impact of Ebola has yet to be fully realized. In the developing world, it has the potential to destabilize entire countries while creating widespread and even regional insecurity. It will have a devastating effect on transportation hubs, economies, healthcare systems, and governments.

The affected areas of West Africa are gripped with superstition, denial, fear and hysteria. Containment of the disease cannot happen without changing the attitudes and knowledge of four levels of society: the general public, healthcare workers, medical professionals, and leadership.

Liberia is full of cultural practices that propagate the spread of the disease, the biggest being the veneration of the dead, including the washing and kissing of the corpse. The corpse of an Ebola victim is at its maximum point of contamination in the hours immediately following death. Every contact with it will result in another infection. This practice is so strongly held that our staff has been faced with violence when the ritual was threatened by attempted collection of a corpse for sanitized burial.

The health care delivery system is built upon the CHW (community health worker), who is most often a moderately educated individual with basic knowledge to identify most commonly present diseases. The symptoms of Ebola are fever, joint pain, diarrhea, and vomiting. Unfortunately these are probably also the symptoms for over half of all diseases they normally encounter. This puts the CHW in the untenable position of having direct exposure to multiple Ebola patients without the knowledge to recognize the disease and the equipment to protect

them. Two weeks ago, we had 12 Ebola cases present to our isolation center in one day, and 8 of the 12 were community health workers. We had no way of knowing how many people they may have contacted before they came to us for help. A special campaign is urgently needed to focus on this select group of health care providers.

The medical profession, that is trained physicians and nurses, also frequently lacks knowledge of Ebola and denies that it is real. We have had nationally known Liberian physicians come to our case management center in Monrovia attempting to examine Ebola cases without wearing any personal protective equipment. We were told by the staff of one prominent doctor that he openly mocked the existence of the virus to his coworkers. A close associate of his was the Liberian/American who traveled to Lagos, Nigeria. These two gentlemen went to the isolation ward at JFK Hospital in Monrovia where the doctor reportedly examined Ebola patients. Both men were dead within a week, one man taking the disease to Nigeria. These men were highly educated, credentialed and respected professionals, yet they did not believe in the existence or the seriousness of the disease. University students in Monrovia today continue to mock and deny the existence of Ebola. These behaviors will not allow the disease to be contained.

These behaviors reflect the need for cultural and societal changes that can only happen with the full support of political, academic and religious leaders. Liberia and West Africa need to have an immediate, concerted and significant effort to educate leaders of government, education and religion to recognize what Ebola is, how it is spread, preventative measures, and what to do if they or a loved one are exposed to the disease so they can prominently and publicly educate others. Certainly Sierra Leone, Guinea, and all of the countries that touch them are in need of the same education and awareness.

The fight against Ebola has to focus on the concept of containment. The virus, regardless of where it came from, now resides on planet Earth and it has the capability to travel at the speed of an airplane. Until there is a vaccine or a cure, we can only fight it by containing it, treating its victims, practicing proper hygiene, and educating.

The Ministries of Health of Liberia, Sierra Leone and Guinea are well intentioned but ill equipped. They face all of the challenges of other countries, such as pointless bureaucracy, corruption, and general dysfunction. While it should be the goal of the developed world to build capacity, the building of this capacity should not be the focus during times of an emergency crisis of a deadly disease that threatens the international community. There needs to be an immediate global coordination which allows the temporary transfer of authority of the national Ministries of Health to an entity to oversee the regional health crisis in order to save lives and stop the international spread of the disease. The entity to lead that coordination must be nimble, effective, resourced, and solely focused on managing the fight against the disease. I know of no such entity that exists today.

The international community should recognize that the Ministries of Health have a primary responsibility for the health of their citizens and a valuable role to play in managing the crisis but at times of great severity, the MOH cannot be expected to carry the lead role.

The World Bank has just committed $200 million to fight the disease. From my 26 years' experience working in global crises and disaster, I wonder where the money will go, what it will actually produce, and what it will actually buy. I fear money alone cannot solve this problem.

Lastly, it is vital that the necessary research and development of a successful vaccine and treatment for Ebola and other hemorrhagic diseases be aggressively sought through research and trials.

In the meantime, it is a nasty, bloody disease that we must fight now.

Thank you.

Ebola Virus | *West Africa: August 6 Update*

Guinea-Bissau

Senegal

Mali

Guinea

Sierra Leone

Liberia

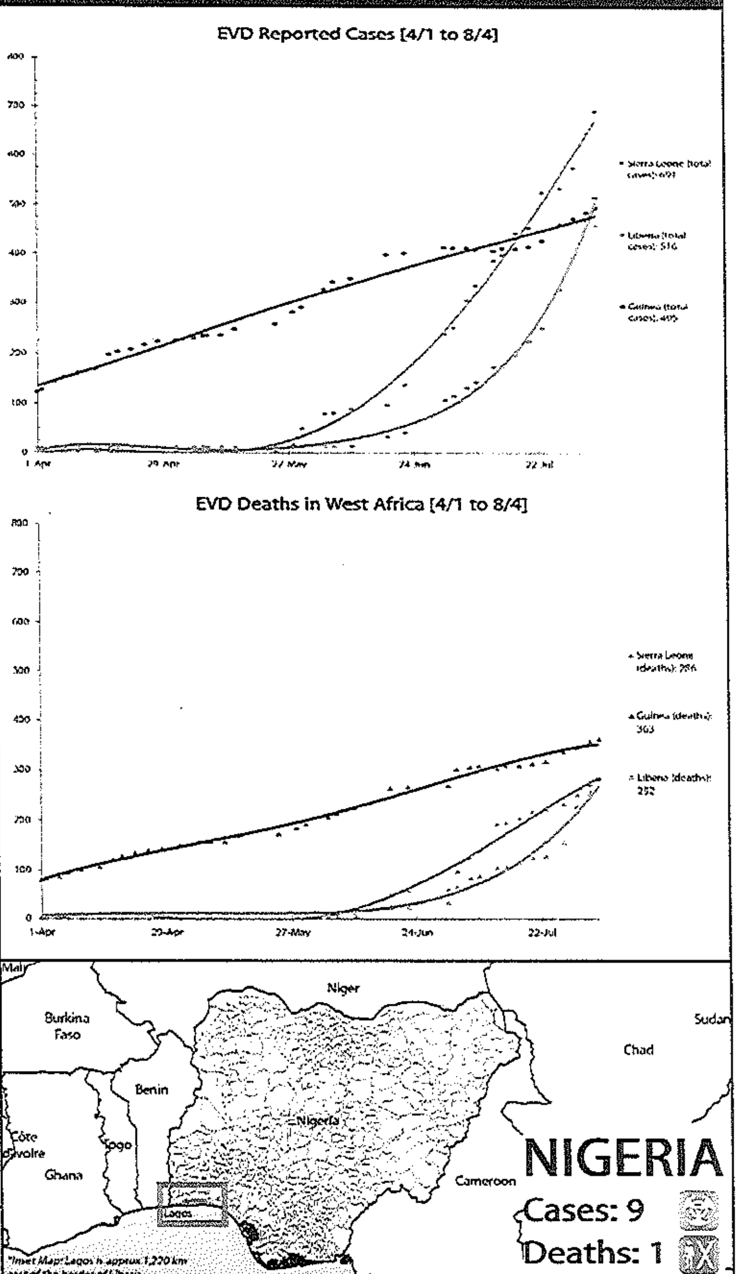
FOYA CMC

ELWA CMC & JFK CMC

GUINEA
Cases: 495
Deaths: 363

SIERRA LEONE
Cases: 691
Deaths: 286

LIBERIA
Cases: 516
Deaths: 282



NIGERIA
Cases: 9
Deaths: 1

*Inset Map: Lagos is approx. 1,220 km east of the border of Liberia.

Legend

Ebola Cases
- Confirmed
- Suspected

Liberia Confirmed Cases
2, 3, 5, 7, 10, 43, 67

Boundary Type
- State
- County
- Country
- Case Management Centers
- CMCs run by Samaritan's Purse

EVD Numbers Reported by WHO (as of 8/4/14)
- Total Cases: 1,711
- Total Deaths: 932

0 75 150 300 Kilometers

Produced by: Samaritan's Purse | Projects, PDD
Data Sources: CDC, ESRI, MOHSW, WHO | Map Projection: Mercator
Scale: 1:2,500,000 | Updated: 8/6/2014

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